

PATIENT'S NAME:

TEL.:
Home

Work

ADDRESS:

PHYSICIAN'S NAME:

TEL.:

– PATIENT IDENTIFIERS NOT TRANSMITTED TO CDC



CHOLERA AND OTHER VIBRIO ILLNESS
SURVEILLANCE REPORT

OMB 0920- 0728 Exp. Date 1/31/2017

SEND COMPLETED REPORT TO STATE INFECTION CONTROL

State will forward to: Centers for Disease Control and Prevention
Enteric Diseases Epidemiology Branch
1600 Clifton Road, MS C09
Atlanta, GA 30333 | Fax 404-639-2205

I. DEMOGRAPHIC AND ISOLATE INFORMATION
REPORTING HEALTH DEPARTMENT

1. First three letters of patient's last name:

State:

City:

County/Parish:

State Epi No.:

State Lab Isolate ID:

CDC USE ONLY

FDA No.

2. Date of birth:
Mo. Day Yr.

3. Age:
Years Mos.

4. Sex:
☐ M (1)
☐ F (2)
☐ Unk. (9)

5. Ethnicity:
Hispanic or Latino Origin?
☐ Yes (1) ☐ Unk. (9)
☐ No (2)

6. Race:
☐ American Indian/ Alaska Native (5)
☐ Asian (4)
☐ Black or African American (2)
☐ Native Hawaiian or other Pacific Islander (6)
☐ White (1) ☐ Unk. (9)

7. Occupation:

8. Vibrio species isolated (check one or more):

Species	Source of specimen(s) collected from patient				Date specimen collected (If more than one specify earliest date)			If wound or other, specify site :
	Stool	Blood	Wound	Other	Mo.	Day	Yr.	
<input type="checkbox"/> <i>V. alginolyticus</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. cholerae</i> O1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. cholerae</i> O139	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. cholerae</i> non -O1, non -O139	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. cincinnatiensis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>Photobacterium damsela</i> subsp. <i>damsela</i> (formerly <i>V. damsela</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. fluvialis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. furnissii</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>Grimontia hollisae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. metschnikovii</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. mimicus</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. parahaemolyticus</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>V. vulnificus</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> <i>Vibrio</i> species -not identified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	
<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>	<div></div>	<div></div>	

9. Were other organisms isolated from the same specimen that yielded *Vibrio*?
Other (specify):

Yes (1) No (2) Unk. (9)

10. Was the identification of the species of *Vibrio* (e.g., *vulnificus*, *fluvialis*) confirmed at the State Public Health Laboratory?

Yes (1) No (2) Unk. (9)

11. Complete the following information if the isolate is *Vibrio cholerae* O1 or O139:

Serotype (check one)
Inaba (1) Not Done (4)
Ogawa (2) Unk. (9)
Hikojima (3)

Biotype (check one)
El Tor (1) Not Done (3)
Classical (2) Unk. (9)

Toxigenic? (check one)
Yes (1) No (2) Unk. (9)

If YES, toxin positive by: (check all, that apply)
ELISA
Latex agglutination
Other (specify):

Name of Hospital: _____

Address: _____
_____State: Age: Sex: **II. CLINICAL INFORMATION***Vibrio* species: _____**1. Date and time of onset of first symptoms:**Mo. Day Yr.
Hour Min. ☐ am (1)
☐ pm (2)**2. Symptoms and signs:**max. ☐ F (1) Yes No Unk. (1) (2) (9)
☐ C (2) .. ☐ ☐ ☐ Fever temp. ☐ ☐ ☐ Headache ☐ (1) (2) (9)
Nausea ☐ ☐ ☐ Muscle pain..... ☐ ☐ ☐
Vomiting ☐ ☐ ☐ Cellulitis..... ☐ ☐ ☐ Site: _____
Diarrhea ☐ ☐ ☐ Bullae..... ☐ ☐ ☐ Site: _____
(max. no. stools/24 hours: _____) Shock ☐ ☐ ☐
Visible blood in stools ☐ ☐ ☐ (systolic BP <90) Other..... ☐ ☐ ☐ (specify): _____
Abdominal cramps ☐ ☐ ☐**3. Total duration of illness:**

(days) _____

4. Admitted to a hospital for this illness?☐ Yes (1) Admission date: Mo. Day Yr.
☐ No (2) Discharge date: Mo. Day Yr.
☐ Unk. (9)**5. Any sequelae? (e.g., amputation, skin graft)**☐ Yes (1) _____
☐ No (2) _____
☐ Unk. (9) _____**6. Did patient die?**☐ Yes (1) If YES, date of death: Mo. Day Yr.
☐ No (2) ☐ ☐ ☐ ☐ ☐ ☐
☐ Unk. (9)**7. Did patient take an antibiotic as treatment for this illness? (643)**Yes No Unk.
(1) (2) (9)
☐ ☐ ☐

If YES, name(s) of antibiotic(s):

1. _____
2. _____
3. _____

Date began antibiotic:

Mo. Day Yr.

Date ended antibiotic:

Mo. Day Yr.

 8. Pre-existing conditions?Yes No Unk. Yes No Unk.
(1) (2) (9) (1) (2) (9)
Alcoholism ☐ ☐ ☐ on insulin? ☐ ☐ ☐
Diabetes ☐ ☐ ☐
Peptic ulcer..... ☐ ☐ ☐ type: _____
Gastric surgery..... ☐ ☐ ☐ Heart failure? ☐ ☐ ☐
Heart disease ☐ ☐ ☐ type: _____
Hematologic disease... ☐ ☐ ☐ type: _____
Immunodeficiency..... ☐ ☐ ☐ type: _____
Liver disease ☐ ☐ ☐ type: _____
Malignancy ☐ ☐ ☐ type: _____
Renal disease ☐ ☐ ☐ type: _____
Other ☐ ☐ ☐ specify: _____**9. Was the patient receiving any of the following treatments or taking any of the following medications in the 30 days before this *Vibrio* illness began?**Yes No Unk. If YES, specify treatment and dates:
(1) (2) (9)
Antibiotics ☐ ☐ ☐ _____
Chemotherapy..... ☐ ☐ ☐ _____
Radiotherapy..... ☐ ☐ ☐ _____
Systemic steroids..... ☐ ☐ ☐ _____
Immunosuppressants.. ☐ ☐ ☐ _____
Antacids..... ☐ ☐ ☐ _____
H₂-Blocker or other.... ☐ ☐ ☐ _____
ulcer medication
(e.g., Tagamet, Zantac, Omeprazole)**III. EPIDEMIOLOGIC INFORMATION****1. Did this case occur as part of an outbreak?**(Two or more cases of *Vibrio* infection)Yes No Unk.
(1) (2) (9)
☐ ☐ ☐

If YES, describe: _____

2. Did the patient travel outside his/her home state in the 7 days before illness began?Patient home state: Yes No Unk.
(1) (2) (9)
☐ ☐ ☐

City/State/Country

1. _____
If YES, list destination(s) and dates:
2. _____
3. _____

Date Entered

Mo. Day Yr.

Date Left

Mo. Day Yr.

 3. Please specify which of the following seafoods were eaten by the patient in the 7 days before illness began: (If multiple times, most recent meal)Type of seafood Yes No Unk. Mo. Day Yr. Any eaten raw?
(1) (2) (9) (1) (2) (9)
Clams ☐ ☐ ☐ ☐ ☐ ☐
Crab ☐ ☐ ☐ ☐ ☐ ☐
Lobster..... ☐ ☐ ☐ ☐ ☐ ☐
Mussels ... ☐ ☐ ☐ ☐ ☐ ☐
Oysters.... ☐ ☐ ☐ ☐ ☐ ☐Type of seafood Yes No Unk. Mo. Day Yr. Any eaten raw?
(1) (2) (9) (1) (2) (9)
Shrimp ... ☐ ☐ ☐ ☐ ☐ ☐
Crawfish... ☐ ☐ ☐ ☐ ☐ ☐
Other shellfish ... ☐ ☐ ☐ ☐ ☐ ☐
(specify): _____
Fish ☐ ☐ ☐ ☐ ☐ ☐
(specify): _____

State: Age: Sex:

III. EPIDEMIOLOGIC INFORMATION (CONT.)

Vibrio species:

4. In the 7 days before illness began, was patient's skin exposed to any of the following?

	Yes (1)	No (2)	Unk. (9)
A body of water (fresh, salt, or brackish water)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drippings from raw or live seafood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other contact with marine or freshwater life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of exposure: Mo. Day Yr.

Time of exposure: Hour Min. ☐ am (1) ☐ pm (2)

If YES, specify body of water location:

If YES, to any of the above, answer each:

	Yes (1)	No (2)	Unk. (9)
Handling/cleaning seafood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming/diving/wading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on beach/shore/ fell on rocks/shells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boating/skiing/surfing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes (1)	No (2)	Unk. (9)
Construction/repairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bitten/stung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• If skin was exposed to water, indicate type:

☐ Salt (1) ☐ Brackish (3) ☐ Unk. (9)
☐ Fresh (2) ☐ Other(specify): (8)

Additional comments:

• If skin was exposed, did the patient sustain a wound during this exposure, or have a pre-existing wound? (choose one):

☐ YES, sustained a wound. (1) ☐ YES, had a pre-existing wound. (2) ☐ YES, uncertain if wound new or old. (3) ☐ NO (4) ☐ Unk. (9)

If YES, describe how wound occurred and site on body :

(Note: Skin bullae that appear as part of the acute illness should be recorded in section II, Clinical Information, only).

If isolate is *Vibrio cholerae* O1 or O139, please answer questions 5 - 8.

5. If patient was infected with *V. cholerae* O1 or O139, to which of the following risks was the patient exposed in the 4 days before illness began:

	Yes (1)	No (2)	Unk. (9)
Raw seafood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooked seafood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other person(s) with cholera or cholera-like illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Street-vended food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(specify):

6. If answered "yes" to foreign travel (question III. 5), had the patient been educated in cholera prevention measures before travel?

If YES, check all source(s) of information received:

<input type="checkbox"/> Pre-travel clinic	<input type="checkbox"/> Friends	<input type="checkbox"/> Travel agency
<input type="checkbox"/> Airport (departure gate)	<input type="checkbox"/> Private physician	<input type="checkbox"/> CDC travelers' hotline
<input type="checkbox"/> Newspaper	<input type="checkbox"/> Health department	<input type="checkbox"/> Other (specify): <input type="text"/>

7. If answered "yes" to foreign travel (question III. 5), what was the patient's reason for travel? (check all that apply)

☐ To visit relatives/friends (1401) ☐ Other (specify):

☐ Business ☐ Unk.

☐ Tourism

☐ Military

8. Has patient ever received a cholera vaccine?

(If YES, specify type most recently received):

☐ Oral ☐ Parenteral

Most recent date: Mo. Day Yr.

If domestically acquired illness due to any *Vibrio* species is suspected to be related to seafood consumption, please complete section IV (Seafood Investigation).

ADDITIONAL INFORMATION or COMMENTS

Person completing section I - III:

Date: Mo. Day Yr.

Title/Agency: Tel.:

CDC Use Only

Source: ☐

Comment:

Syndrome: ☐

CDC Isolate No.

State: Age: Sex:

IV. SEAFOOD INVESTIGATION SECTION

Vibrio species: _____

**For each seafood ingestion investigated, please complete as many of the following questions as possible.
(Include additional pages section IV if more than one seafood type was ingested and investigated.)**

1. Type of seafood (e.g., clams): _____ Date consumed: Mo. Day Yr. Time consumed: Hour Min. ☐ am (1) ☐ pm (2) Amount consumed:

If patient ate multiple seafoods in the 7 days before onset of illness, please note why this seafood was investigated (e.g., consumed raw, implicated in outbreak investigation): _____

2. How was this fish or seafood prepared?

☐ Raw (1) ☐ Baked (2) ☐ Boiled (3) ☐ Broiled (4) ☐ Fried (5) ☐ Steamed (6) ☐ Unk. (9) ☐ Other (8) (specify): _____

3. Was seafood imported from another country?

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

If YES, specify exporting country if known: _____

4. Was this fish or shellfish harvested by the patient or a friend of the patient?

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

(If YES, go to question 12.)

5. Where was this seafood obtained? (Check one)

☐ Oyster bar or restaurant (1) ☐ Seafood market (4)
☐ Truck or roadside vendor (2) ☐ Other (8) (specify): _____
☐ Food store (3)

6. Name of restaurant, oyster bar, or food store: _____ Tel: _____

Address: _____

7. If oysters, clams, or mussels were eaten, how were they distributed to the retail outlet? (1591)

☐ Shellstock (sold in the shell) (1) ☐ Shucked (2) ☐ Unk. (9) ☐ Other (8) (specify): _____

8. Date restaurant or food outlet received seafood:

Mo. Day Yr.

9. Was this restaurant or food outlet inspected as part of this investigation?

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

10. Are shipping tags available from the suspect lot?

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

(Attach copies if available)

11. Shippers who handled suspected seafood: (please include certification numbers if on tags)

12. Source(s) of seafood:

13. Harvest site:

Date:

Mo. Day Yr.

Status:

☐ Approved (1) ☐ Conditional (3)
☐ Prohibited (2) ☐ Other (8) (specify): _____
☐ Approved (1) ☐ Conditional (3)
☐ Prohibited (2) ☐ Other (8) (specify): _____

14. Physical characteristics of harvest area as close as possible to harvest date:

Maximum ambient temp.

Result

☐ F (1) ☐ C (2)

Date Measured

Mo. Day Yr.

Surface water temp.

☐ F (1) ☐ C (2)

Mo. Day Yr.

Salinity (ppt)

Mo. Day Yr.

Total rainfall (inches in prev. 5 days)

Mo. Day Yr.

Fecal coliform count

Mo. Day Yr.

(Attach copy of coliform data)

15. Was there evidence of improper storage, cross-contamination, or holding temperature at any point?

Yes (1) ☐ No (2) ☐ Unk. (9) ☐

If YES, specify deficiencies: _____

Person completing section IV:

Date:

Mo. Day Yr.

Title/Agency:

Tel.:
